

CRITERIA FOR PRIOR AUTHORIZATION

Alpha Interferon

PROVIDER GROUP Pharmacy
Professional

MANUAL GUIDELINES The following drug requires prior authorization:
Interferon alfa-2b (Intron® A)

CRITERIA FOR HAIRY CELL LEUKEMIA Must meet all of the following:

- Patient must have a diagnosis of hairy cell leukemia
- Must be prescribed by or in consultation with an oncologist
- Patient must be 18 years of age or older

LENGTH OF APPROVAL FOR HAIRY CELL LEUKEMIA 1 year

CRITERIA FOR MALIGNANT MELANOMA Must meet all of the following:

- Patient must have a diagnosis of malignant melanoma
- Must be prescribed by or in consultation with an oncologist
- Patient must be 18 years of age or older
- Patient must have had surgery within 56 days of treatment with Intron A

LENGTH OF APPROVAL FOR MALIGNANT MELANOMA 1 year

CRITERIA FOR FOLLICULAR LYMPHOMA Must meet all of the following:

- Patient must have a diagnosis of follicular lymphoma
- Must be prescribed by or in consultation with an oncologist
- Patient must be 18 years of age or older
- Must be used in combination with anthracycline-containing chemotherapy

LENGTH OF APPROVAL FOR FOLLICULAR LYMPHOMA 1 year

CRITERIA FOR CONDYLOMATA ACUMINATA Must meet all of the following:

- Patient must have a diagnosis of condylomata acuminata
- Must be prescribed by or in consultation with a dermatologist or infectious disease specialist
- Patient must be 18 years of age or older

LENGTH OF APPROVAL FOR CONDYLOMATA ACUMINATA 1 year

CRITERIA FOR AIDS-RELATED KAPOSI'S SARCOMA Must meet all of the following:

- Patient must have a diagnosis of AIDS-related Kaposi's sarcoma
- Must be prescribed by or in consultation with an oncologist or infectious disease specialist
- Patient must be 18 years of age or older

LENGTH OF APPROVAL FOR AIDS-RELATED KAPOSI'S SARCOMA 1 year

CRITERIA FOR CHRONIC HEPATITIS B Must meet all of the following:

- Patient must have a diagnosis of chronic hepatitis B
- Patient must have been serum HBsAg positive for at least 6 months
- Patient must have evidence of HBV replication defined as one of the following
 - HBeAg positive patients – HBV DNA level >20,000 IU/mL
 - HBeAg negative patients – HBV DNA level \geq 2,000 IU/mL
- Patient must have evidence of active liver disease demonstrated by one of the following
 - persistent elevation in serum ALT (\geq 2 times upper limits of normal)
 - moderate to severe hepatitis or fibrosis on biopsy
 - evidence of icteric ALT flare ups
- Must be prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist
- Patient must be 1 year of age or older
- Patient must not have decompensated liver disease
- Patient has not previously completed a full course of therapy with interferon or peginterferon

LENGTH OF APPROVAL FOR CHRONIC HEPATITIS B 24 weeks (patients <18 years of age)
16 weeks (patients \geq 18 years of age)

CRITERIA FOR INITIAL APPROVAL FOR CHRONIC HEPATITIS C Must meet all of the following:

- Patient must have a diagnosis of chronic hepatitis C
- Must be prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist
- Patient must be 3 years of age or older
- Patient has a detectable hepatitis C viral level (HCV RNA) in the serum
- Patient is positive for HCV antibodies
- Patient must not have decompensated liver disease
- Patients 3 to 18 years of age must take Intron A in combination with ribavirin unless patient has a contraindication or intolerance to ribavirin therapy

RENEWAL CRITERIA FOR CHRONIC HEPATITIS C Must meet all of the following:

- Patient has normalization of ALT at 16 weeks
 - For patients who do not normalize their ALTs after 16 weeks of therapy rarely achieve a sustained response with extension treatment. Consideration should be given to discontinuing these patients from therapy

LENGTH OF APPROVAL FOR CHRONIC HEPATITIS C 16 weeks (up to 96 weeks of total therapy)